Healthcare Reform and the General Surgeon

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The impact of health reform (ACA) on the field of surgery, and a 2011 update

- The perspective of the American College of Surgeons
- The perspective of a surgeon from an academic medical center
- Personal recommendations for the practicing general surgeon

“Healthcare is a public good”
What are the implications of ACA for surgeons?

Expanding coverage to 32 million Americans may overwhelm an already struggling delivery system. The care of undocumented immigrants was not resolved.

Without an SGR fix, many surgeons are considering dropping out of Medicare.

Payment and delivery reform:
1) Independent Payment Advisory Board
2) PCORI
3) A Center for Medicare Innovation
4) Will the medical home raise costs?
5) Increased support of rural surgeons
6) Redistribution of general surgery residency positions

The ACS priorities – Executive Director
Dr. David Hoyt

October 2010

1) Payment reform & SGR fix
2) Accountable care organizations
3) Center for Medicare & Medicaid Innovation
4) Bundling
5) P4P and NSQIP

“ACA is the blueprint for a whole new care delivery system… it is up to us to do everything that we can to make sure that the final structure is sound and equitable for surgeons and patients.”
Who will care for the 32 million additional Americas?

The fundamental flaw of ACA highlighted by the Palo Alto tragedy....

The hard work of implementing a law....

- A provision of PPACA to create a “value index” would add a payment modifier to the Physician Fee Schedule
- “Quality is to be evaluated on a composite of risk-adjusted measures established by the Secretary. Costs are to be evaluated based on a composite of appropriate measures of costs established by the Secretary that eliminate the effect of geographic adjustments and take into account risk factors ... and other factors determined appropriate by the Secretary.”

We’re all about creating value in the health care system BUT to say that the HHS secretary can determine how quality is defined is not going to work. It has to be up to the people providing care and their specialty groups to determine what is “value-based care.”
How a bill (except ACA) becomes a law

Putting the Brakes on ObamaCare
How a Republican Congress could begin the process of repealing this unpopular law.
By SPACE WAR TURNER

If Republicans take control of one or both houses of Congress this fall, many will have been elected with a promise to “repel and replace” ObamaCare. But what are their options, really? There likely will be a lot of rhetoric, but President Obama will need to see any challenge to the law, and it would be hard to imagine overcoming the veto to overturn it.

Information is the key weapon: Republicans can use congressional hearings to explain what ObamaCare is doing to the economy and the health sector. Their strongest case would be built around jobs, the cost of health care, and the rising deficit.

If evidence shows that looming mandates on employers are crippling job creation, they should be repealed. If health costs are rising, as they have been, Congress needs to hold hearings to investigate the causes and explain why the offending taxes and regulations must be repealed.

Here are six key strategies that a Republican Congress could employ to put on the brakes:

• Defund It: House Republicans Leader John Boehner of Ohio has vowed to choke off funding for implementation of the legislation, starting with parts that are especially egregious such as the “array of new IRS agents” needed to police compliance.

• Unroll It: To focus Congress’s action and floor votes, Republicans look for provisions in the law that Democrats are on record as opposing. For example, Senate Budget Committee Chairman Kent Conrad (D., N.D.) has said that the new federal program to fund long-term care—-the Community Living Assistance Services and Supports Act, or CLASS Act—is “a Ponzi scheme of the first order,” the kind of thing that Barbara Mikulski would have been proud of.
What is the American perception?

December 2010 – 48% of Americans think the law has been repealed or is no longer being implemented.

February 2011 – Kaiser poll reveals 90% of Republicans, 69% of Independents, and 51% of Democrats want ACA repealed.

Public opinion has not shifted favorably one year after the passage of ACA

What are the next steps in DC?

March 2011 – HHS has granted:
1) 1,040 mini-med waivers
2) Maine was granted a MLR waiver (NH, NV, and KY next)
3) Oregon and Vermont will seek State Innovation Waivers

Feb 2012 - Iowa and New Hampshire caucus for the Presidential election of 2012 – Mitt Romney could be a liability

“Health care reform is trench warfare. It is always won on defense—whoever is advancing is getting gunned down”
Supreme Court is anticipated to *grant cert* and rule next summer

The current score is 3 to 2 (pro/con) in District Courts about the constitutionality of the individual mandate

Former Massachusetts Treasurer Tim Cahill (D) and “Romneycare”

“No other program has grown faster, and ripped a gaping hole in the commonwealth’s budget. When universal coverage was sold to voters in 2006, they were told that it would cost about $88 million/year. The true cost to cover a mere 4% more was more than $4 billion.”

*Per capita health expenditures in Massachusetts are highest in the nation, and 27% higher than the national average in 2010*

A key lesson: Financial projections are often wrong.
Why are surgeons concerned?

If a child has a bad sore throat or has repeated sore throats, the doctor may look at the reimbursement system and say to himself, You know what? I make a lot more money if I take this kid's tonsils out.

Obama Town Hall, New Hampshire August 2009

Let's take the example of diabetes --- a disease that's skyrocketing, partly because of obesity, partly because it's not treated as effectively as it could be. Right now -- if a family care physician works with a patient to help them lose weight, modify diet, monitors whether they're taking their medications in a timely fashion, they might get reimbursed a pittance. But if that same diabetic ends up getting their foot amputated, that's $30,000, $40,000, $50,000 -- immediately the surgeon is reimbursed.
CMA expresses deep concerns about President Obama’s comments  August 13, 2009

In the first example, he stated that surgeons make $30,000 to $50,000 to amputate a foot of a diabetic. This assertion is false. Medicare pays surgeons $589 to $767 for a foot amputation. Medi-Cal pays $420 for the same. Hospital and other associated costs may add up to the greater amount, but it is incorrect and misleading to suggest the surgeon’s costs are responsible for that figure.

In the second example, the President suggested that physicians take out children’s tonsils to make more money. This implication is inaccurate and offensive.

ACS Responds to President Obama

Statement from L.D. Britt, MD, FACS, Chair of the Board of Regents: "President Obama's unfortunate remarks during his July 22 press conference in which he suggested that a physician’s decision to remove a child’s tonsils – or any other procedure – is based on making “a lot more money,” was ill-informed and dangerous. We were dismayed at this characterization."

Over the past year, the ACS has been actively engaged in health care reform discussions. We have participated in good faith with the Administration and Congressional leaders and have come to the table with open minds and an attitude that we are ‘all in this together’ to fix this hugely complex problem.
Eight rules for Presidents from “The Heart of Power”

1) Have Passion
2) Speed
3) Bring a Plan with You
4) Hush the Economists
5) Go Public
6) Manage Congress
7) Forget the PSRO’s
8) Learn How to Lose

The art of politics

Politics is the art of looking for trouble, finding it everywhere, diagnosing it incorrectly, and applying the wrong remedies. *Earnest Benn*

The scariest words in the English language are “I'm from the government and I am here to help.”
Strengths of the American Medical Delivery system – much to be proud of!

- Shortest waiting time for elective surgery
- 40% of the world’s medical tourists travel to the US
- 1st or second in kidney, liver, heart transplants, knee replacements, CABG, and angioplasty
- More Nobel Prizes than all other nations combined
- Highest breast, colon and prostate cancer survival in the world
- Trainees travel from around the world to US medical schools and residency programs
- Leading research performed here is published worldwide and shared through NEJM and JAMA
- 8 of the 10 top selling medications worldwide are made by US companies

The studies concluding European systems are superior - are from Europe!

There are actually two WHO reports in 2000. The first ranked the US 15th, the other 37th.

The criteria were:
1) Health level 25%
2) Health distribution 25%
3) Health responsiveness 12.5%
4) Responsiveness distribution 12.5%
5) Financial fairness 25%

Only # 1 and # 3 are measures of the medical delivery system. The US was ranked first in # 3

The other measures reflect disparities, financing, equity and societal values.
Fundamental point of the WHO report - Christopher Murray Director of Health

"Although significant progress has been achieved in past decades, virtually all countries are underutilizing the resources that are available to them. This leads to large numbers of preventable deaths and disabilities; unnecessary suffering, injustice, inequality and denial of an individual's basic rights to health."

"The poor are treated with less respect, given less choice of service providers and offered lower-quality amenities. In trying to buy health from their own pockets, they pay and become poorer."

Perhaps the problem in America has been framed incorrectly

The primary problem with healthcare-the profit motive?

In remarkably candid interviews, doctors, hospital administrators, patients, health care economists, corporate executives, and Wall Street analysts describe a war of “all against all” that can turn physicians, hospitals, insurers, drugmakers, and device makers into blood rivals.

“More care is not better care”
The challenges of a single payer system

Variations in spending among "best" academic medical centers

Spending per Medicare beneficiary with severe chronic disease (Last 2 years of life, 2000-2003)

- Cedars Sinai (LA) $7,934
- UCLA Medical Center $7,793
- New York Presbyterian $7,692
- Johns Hopkins $6,950
- UCSF Medical Center $6,950
- Univ. of Washington $5,786
- Mass. General $4,889
- Barrow - Phoenix $4,400
- Duke University Hosp. $3,765
- Mayo Clinic (St. Mary's) $3,771
- Cleveland Clinic $2,655

How can the best medical care in the world cost twice as much as the best medical care in the world?

Use Rand/ach

Medical center profits

Factors Affecting Real Annual Growth Rate in Hospital Expenditures 2000-2012

- Population Growth 18%
- Per Capita Real Growth 18%
- Excess Hospital Inflation 18%
- Adjusted for Inflation 18%
Key questions for the profession of surgery moving beyond ACA

- What misunderstandings persist?
- How do we define value in surgery?
- Value = technical quality + access + customer satisfaction + healthcare status (cost or price)
- Congress believes transparency is bad?
- Will comparative effectiveness research succeed?
- What is the future of the accountable care organization?

The history of politics influencing comparative effectiveness research

- Agency for Health Care Policy and Research impaneled a group of 23 experts in 1993 to draft guidelines to best treat back pain.
- They found little evidence to support surgery as first-line treatment
- In 1995 the House eliminated the "Agency for High Cost Publications and Research."
- Eventually saved and renamed AHRQ with a slashed budget
- There are 13,000 diagnoses, 6000 medications and 4000 types of procedures performed. Can we study all of these?

The questions stay the same, but the answers change
Sir Michael Rawlins of NICE and the challenges of Value Based Purchasing

1) The dearth of direct comparative effectiveness studies between interventions (they instead compare to placebo)
2) The limits in applying the results of clinical trials to the real world
3) The unclear translation of clinical effectiveness into value
4) The complexities of drawing conclusions that are based on cost-effectiveness

How to create a framework to decide value in the context of resource constraints and necessary value trade-offs?

Accountable care organization or health maintenance organization?

By contracting with specific providers of health care and dealing with large quantities of patients, the organization is better able to negotiate for more affordable health care than the patients would otherwise receive.

Secondly, by eliminating treatments that are unnecessary, and by focusing on preventative health care with an eye toward long-term health, costs are reduced.
ACO or HMO?

The goal is to pay providers in a way that encourages them to work together, to pay providers in a way that does not encourage supplier induced demand, and to create an organization that is rewarded for providing high quality care.

Conclusions for next steps for our society – reframing the discussion

- Reconnect the link between payor and recipient
- Incorporate patient responsibility and accountability
- Reduce profiteering
- Reform the reliance on employer based healthcare to promote equity
- Achieve greater standardization in care, expectations in outcomes
- Recognize that too much is already spent on healthcare
- Consider a shift of focus to emergency care
- We may need to do fewer procedures.
- Rationing will need to be considered carefully

*Healthcare is a public good.*